



**State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030**

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CONNECTICUT OFFICE OF
HEALTH CARE ACCESS

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Rushford Center Inc.	
Doing Business As	Same	
Name of Parent Corporation	Hartford Healthcare Corporation	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	384 Pratt Street Meriden, CT 06450	
Applicant type (e.g., profit/non-profit)	Non-profit	
Contact person, including title or position	John Habif, Dir. Quality Mgmt	
Contact person's street mailing address	Same	
Contact person's phone #, fax # and e-mail address	203-238-6802 (phone) 203-634-2799 (fax)	

SECTION II. GENERAL APPLICATION INFORMATION

- a. Proposal/Project Title: Meriden Substance Abuse Intermediate Program Termination
-
- b. Type of Proposal, please check all that apply:
- ☒ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:
- ☐ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)
- ☐ Expansion (F, S, Fnc) ☐ Relocation ☒ Service Termination
- ☐ Bed Addition ☐ Bed Reduction ☐ Change in Ownership/Control
- ☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:
- ☐ Project expenditure/cost cost greater than \$ 1,000,000
- ☐ Equipment Acquisition greater than \$ 400,000
- ☐ New ☐ Replacement ☐ Major Medical
- ☐ Imaging ☐ Linear Accelerator
- ☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over \$1,000,000
- c. Location of proposal (Town including street address):
48 St. Casimir Drive, Meriden, CT 06450
- d. List all the municipalities this project is intended to serve:
Meriden, Wallingford
- e. Estimated starting date for the project: July 1, 2006

- f. Type of project: 9 (Fill in the appropriate number(s) from page 7 of this form)

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

- a. Estimated Total Capital Expenditure: — 0 —
- b. Please provide the following breakdown as appropriate:

Construction/Renovations	
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	\$0.00
Fair Market Value of Leased Equipment	
Total Capital Cost	\$0.00

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

- ☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan
☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding
☐ Funded Depreciation ☐ Other (specify):

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT N/A

I may be eligible for a waiver from the Certificate of Need process because of the following:
(Please check all that apply)

This request is for Replacement Equipment.

The original equipment was authorized by the Commission/OHCA in Docket
Number: _____.

The cost of the equipment is not to exceed \$2,000,000.

The cost of the replacement equipment does not exceed the original cost
increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: Rushford Center Inc.

Project Title: Meriden Substance Abuse Intermediate Program Ter

I, Jeffrey Walter, CEO
(Name) (Position – CEO or CFO)

of Rushford Center Inc. being duly sworn, depose and state that the
information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to
the best of my knowledge, and that Rushford Center Inc. complies with the appropriate and
(Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486
and/or 4-181 of the Connecticut General Statutes.

Jeffrey Walter
Signature

4/3/06
Date

Subscribed and sworn to before me on 4/3/06

[Signature]
Notary Public/Commissioner of Superior Court

My commission expires: 3-31-2010

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
- ☒ 9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Abuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

SECTION IV. PROJECT DESCRIPTION

1. Currently what types of services are being provided?

Rushford Center currently provides an eight-bed intermediate (residential) substance abuse treatment program at 43 St. Casimir Drive in Meriden. A copy of the applicable DPH license is attached.

2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?

Rushford seeks approval for the termination of this service at this site.

3. Who is the current population served and who is the target population to be served?

The current population served is comprised of males, ages 18 and above, who are in recovery from alcoholism and other drug dependencies.

4. Identify any unmet need and how this project will fulfill that need.

The need for this service is met through other existing residential treatment providers in the central Connecticut area as well as so-called sober living residences in the community.

5. Are there any similar existing service providers in the proposed geographic area?

Rushford provides this level of care at its Middletown facility. Other similar programs are located in New Britain, Waterbury and New Haven.

6. What is the effect of this project on the health care delivery system in the State of Connecticut?

The applicant believes that the termination of this service will have no effect on the health care delivery system. This is because of the existence of similar services and sober living residences in the local and surrounding communities.

7. Who will be responsible for providing the service?

This LOI is for termination of service.

8. Who are the payers of this service?

The primary payer is the General Assistance Behavioral Health Program (GABHP) administered by the Department of Mental Health and Addiction Services.

STATE OF CONNECTICUT
Department of Public Health

LICENSE

License No. 0257

**Facility for the Care or Treatment of Substance
Abusive or Dependent Persons**

In accordance with the provisions of the General Statutes of Connecticut Section 19a-493:

Rushford Center, Inc. of Meriden, CT, d/b/a Rushford Center Inc. is hereby licensed to maintain and operate a Facility for the Care or Treatment of Substance Abusive or Dependent Persons.

Rushford Center Inc. is located at 43 St. Casimir Drive, Meriden, CT 06450 with:

Jeffrey Walter as Executive Director

The maximum number of beds shall not exceed at any time:

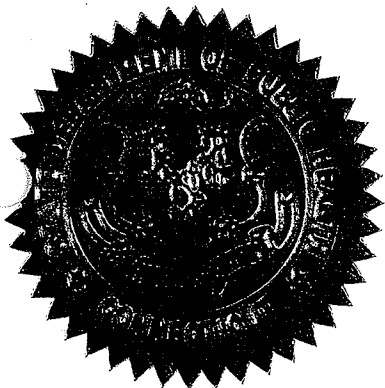
8 Intermediate and Long Term Treatment and Rehabilitation Beds

The service classification(s) and if applicable, the residential capacities are as follows:

Intermediate and Long Term Treatment and Rehabilitation

This license expires **December 31, 2007** and may be revoked for cause at any time.

Dated at Hartford, Connecticut, January 1, 2006. RENEWAL.



J Robert Galvin M.D., M.P.H.

J. Robert Galvin, M.D., M.P.H.,
Commissioner